Apollo
TOUCHING LIVES

Apollo Clinic
VASHI

MEDICAL SUMMARY

NAME:	Ms. Harshila	UHID:	
AGE:	33	DATE OF HEALTHCHECK:	9-12-2023
GENDER:	F		

HEIGHT:	150.5	MARITAL STATUS:	Single
WEIGHT:	61.5	NO OF CHILDREN:	
BMI:	27.2		

C/O: Low BP

K/C/O:
PRESENT MEDICATION: — Not taking

P/M/H: Depression - stopped medicine - June 2023

P/S/H: Cyst removal → lumbar region - 4 times

ALLERGY: — No

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

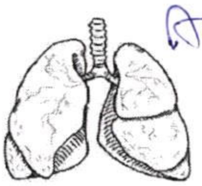
H/A: SMOKING: No
ALCOHOL: No
TOBACCO/PAN: No

FAMILY HISTORY FATHER: —
MOTHER: — Thyroid Dysfunction

O/E:
BP: 100/60 PULSE: — 70/min
TEMPERATURE: Normal SCARS:

LYMPHADENOPATHY: NAD
PALLOR/ICTERUS/CYNOSIS/CLUBBING: NAD
OEDEMA: NAD

S/E:
RS: AEBE



P/A: NAD

CVS: S1S2+

Extremities & Spine: knee pain

ENT: — NAD

CNS: Conscious, oriented

Skin: — Acne ? Dermatitis.

Vision:

	Without Glass		With Glass	
	Right Eye	Left Eye	Right Eye	Left Eye
FAR :				
NEAR :				
COLOUR VISION:				

Vashi : M/S. Indira Health & Lifestyle Pvt. Ltd. The Emerald, 1st Floor, Plot No. 195, Sector - 12, Besides Neel Siddhi Tower, Vashi - Navi Mumbai - 400703.
Tel.: (022) - 2788 1322 / 23 / 24 8291490000 • Email: apolloclinicvashi@gmail.com

Name: Harshika	Age: 33	Date of Health check-up: 9/12/2023

Findings and Recommendation:

Findings:-

S. Alk - Phosphatase
- 118 U/L
ECG - Sinus Bradycardia

Rest reports WNL

Recommendation:-

Signature:

Consultant –

DR. PRADNYA P. DANI
(M.B.B.S)
Reg. No. 87541

Apollo

Apollo Clinic VASHI

OPHTHALMIC EVALUATION

UHID No.: _____ Date : 9/12/23

Name : Ms. Harshika Age : 33 y Gender : Male/Female

Without Correction :

Distance: Right Eye _____ Left Eye _____

Near : Right Eye _____ Left Eye _____

With Correction :

Distance: Right Eye 6/6 Left Eye 6/6.

Near : Right Eye N-6 Left Eye N-6

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance										
Near										

Colour Vision : (BE) - WNL

Anterior Segment Examination : (BE) - WNL

Pupils : (BE) - WNL.

Fundus : (BE) - WNL

Intraocular Pressure : _____

Diagnosis : (BE) - WNL

Advice : _____

Re-Check on _____ (This Prescription needs verification every year)

Dr. Sagorika Dey
(Consultant Ophthalmologist)

DR. SAGORIKA DEY
MBBS, DOMS
REGN NO: 2008/04/1182

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DENTAL CHECKUP

Name: Harshika	**MR NO:**
Age/Gender : 33 / F	**Date:** 9/12/23

Medical history: ☐ Diabetes ☑ Hypertension ☐ _____

EXAMINATION	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Calculus& Stains			✓	✓
Mobility				
Caries (Cavities)				
a)Class 1 (Occlusal)				
b)Class 2 (Proximal)				
c)Class 5 (Cervical)				
Faulty Restoration				
Faulty Crown				
Fractured Tooth				
Root Pieces				
Impacted Tooth				
Missing Tooth				
Existing Denture				

TREATMENT ADVICED:

TREATMENT	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Restoration / Filling				
Root Canal Therapy				
Crown				
Extraction				

Oral Prophylaxis: ☐ Scaling & polishing
Orthodontic Advice for Braces: ☑ Yes / ☐ No
Prosthetic Advice to Replace Missing Teeth: ☐ Denture ☐ Bridge ☐ Implant
Oral Habits: ☐ Tobacco ☐ Cigarette ☐ Others since ____ years
☐ Advice to quit any form of tobacco as it can cause cancer.
Other Findings: _____

- Adv OPG.
- Start flossing.

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Name : Ms Harshika Age : 33 Sex : F UHID No. : Date : 9/12/2023

33 years F/ unmarried

No complain
Not willing for PAPsmear

LMP - 21/11/2023.

O/E

G.C fair
Afebrile -

P - 72/min

PA - soft NT

P/s

P/v | Not done

F/u sos.

Dr. DR TRUPTI SHINDE

DR. TRUPTI VIJAY SHINDE
MBBS, M.S. (OBS & GYNAE)
REG. NO.: 2014/07/3301

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Apollo Clinic VASHI

MC-2364

Name	: Ms. Harshika	Gender	: Female	Age	: 33 Years
UHID	: FVAH 9704	Bill No	:	Lab No	: V-2169-23
Ref. by	: SELF	Sample Col.Dt	: 09/12/2023 9:15		
Barcode No	: 9292	Reported On	: 09/12/2023 18:22		

TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
CBC (Complete Blood Count)-WB (EDTA)			
Haemoglobin(Colorimetric method)	11.8	g/dl	11.5 - 15
RBC Count (Impedance)	4.17	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	37.5	%	35 - 55
MCV:(Calculated parameter)	90	fl	78 - 98
MCH:(Calculated parameter)	28.3	pg	26 - 34
MCHC:(Calculated parameter)	31.5	gm/dl	30 - 36
RDW-CV:	14.4	%	10 - 16
Total Leucocyte count(Impedance)	6530	/cumm.	4000 - 10500
Neutrophils:	64	%	40 - 75
Lymphocytes:	31	%	20 - 40
Eosinophils:	02	%	0 - 6
Monocytes:	03	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	3.07	Lakhs/c.mm	1.5 - 4.5
MPV	10.2	fl	6.0 - 11.0
Peripheral Smear (Microscopic examination)			
RBCs:	Normochromic,Normocytic		
WBCs:	Normal		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter.		

Vasanti Gondal
Entered By

Ms Kaveri Gaonkar
Verified By

Dr. Milind Patwardhan
M.D(Path)
Chief Pathologist

End of Report
Results are to be correlated clinically

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL

ESR(Westergren Method)

Erythrocyte Sedimentation Rate:-	**27**	mm/1st hr	0 - 20

Ms Kaveri Gaonkar
Entered By

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Chief Pathologist

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TEST	RESULTS

Blood Grouping (ABO & Rh)-WB(EDTA) Serum

ABO Group:	**:O:**
Rh Type:	**Positive**
Method :	Matrix gel card method (forward and reverse)

Pooja Surve
Entered By

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL

PLASMA GLUCOSE

Fasting Plasma Glucose :	95	mg/dL	Normal < 100 mg/dL Impaired Fasting glucose : 101 to 125 mg/dL Diabetes Mellitus : >= 126 mg/dL (on more than one occasion) (American diabetes association guidlines 2016)
Post Prandial Plasma Glucose :	96	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : >= 200 mg/dL (on more than one occasion) (American diabetes association guidlines 2016)
Method :	Hexokinase		

Alsaba Shaikh
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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin :	5.3	%	Normal <5.7 % Pre Diabetic 5.7 - 6.5 % Diabetic >6.5 % Target for Diabetes on therapy < 7.0 % Re-evalution of therapy > 8.0 %
Mean Blood Glucose :	105.41	mg/dL	

Corelation of A1C with average glucose

A1C (%)	Mean Blood Glucose (mg/dl)
6	126
7	154
8	183
9	212
10	240
11	269
12	298

Method — High Performance Liquid Chromatography (HPLC).

INTERPRETATION

* The HbA1c levels corelate with the mean glucose concentration prevailing in the course of Pts recent history (apprx 6-8 weeks) & therefore provides much more reliable information for glycemia control than the blood glucose or urinary glucose.
* This Methodology is better then the routine chromatographic methods & also for the daibetic pts.having HEMOGLBINOPATHIES OR UREMIA as Hb varaints and uremia does not INTERFERE with the results in this methodology.
* It is recommended that HbA1c levels be performed at 4 - 8 weeks during therapy in uncontrolled DM pts.& every 3 - 4 months in well controlled daibetics .
* Mean blood glucose (MBG) in first 30 days (0-30)before sampling for HbA1c contributes 50% whereas MBG in 90 - 120 days contribute to 10% final HbA1c levels

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LIPID PROFILE - Serum			
S. Cholesterol(Oxidase)	180	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	80	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	16	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	45.0	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	119	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	4		3.5 - 5
Ratio of LDL/HDL	2.6		2.5 - 3.5

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LFT(Liver Function Tests)-Serum			
S.Total Protein (Biuret method)	7.32	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.18	g/dL	3.5 - 5.2
S.Globulin (Calculated)	3.14	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.33		0.9 - 2
S.Total Bilirubin (DPD):	0.29	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.12	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.17	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	17	U/L	5 - 32
S.ALT (SGPT) (IFCC Kinetic with P5P):	12	U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic):	**118**	U/L	35 - 105
S.GGT(IFCC Kinetic):	22	U/L	07 - 32

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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY		
S.Urea(Urease Method)	12.5	mg/dl	10.0 - 45.0
BUN (Calculated)	5.83	mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.56	mg/dl	0.50 - 1.1
BUN / Creatinine Ratio	10.41		9:1 - 23:1
S.Uric Acid(Uricase Method)	3.5	mg/dl	2.4 - 5.7

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MC-2364

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Thyroid (T3,T4,TSH)- Serum			
Total T3 (Tri-iodo Thyronine) (ECLIA)	2.51	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	116.4	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	4.58	□IU/ml	Euthyroid :0.35 - 5.50 □IU/ml Hyperthyroid : < 0.35 □IU/ml Hypothyroid : > 5.50 □IU/ml

Grey zone values observed in physiological/therapeutic effect.

Note:

T3 :

1. Decreased values of T3 (T4 and TSH normal) have minimal Clinical significance and not recommended for diagnosis of hypothyrodism.
2. Total T3 and T4 values may also be altered in other conditions due to changes in serum proteins or binding sites ,Pregnancy, Drugs (Androgens,Estrogens,O C pills, Phenytoin) etc. In such cases Free T3 and free T4 give corrected Values.
3. Total T3 may decrease by < 25 percent in healthy older individuals

T4 :

1. Total T3 and T4 Values may also be altered in other condition due to changes in serum proteins or binding sites, Pregnancy Drugs (Androgens,Estrogens,O C pills, Phenytoin), Nerphrosis etc. In such cases Free T3 and Free T4 give Corrected values.

TSH :

1. TSH Values may be transiently altered because of non thyroidal illness like severe infections,liver disease, renal and heart failure. Severe burns, trauma and surgery etc.
2. Drugs that decrease TSH values e,g L dopa, Glucocorticoids.
3. Drugs that increase TSH values e.g. Iodine,Lithium, Amiodarone

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URINE REPORT

TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
PHYSICAL EXAMINATION		
QUANTITY	10 mL	
COLOUR	Pale Yellow	
APPEARANCE	Slightly Hazy	Clear
SEDIMENT	Absent	Absent
CHEMICAL EXAMINATION(Strip Method)		
REACTION(PH)	7.0	4.6 - 8.0
SPECIFIC GRAVITY	1.005	1.005 - 1.030
URINE ALBUMIN	Absent	Absent
URINE SUGAR(Qualitative)	Absent	Absent
KETONES	Absent	Absent
BILE SALTS	Absent	Absent
BILE PIGMENTS	Absent	Absent
UROBILINOGEN	Normal(<1 mg/dl)	Normal
OCCULT BLOOD	Absent	Absent
Nitrites	Absent	Absent
MICROSCOPIC EXAMINATION		
PUS CELLS	2 - 3 / hpf	0 - 3/hpf
RED BLOOD CELLS	Nil /HPF	Absent
EPITHELIAL CELLS	**12 - 15 / hpf**	3 - 4/hpf
CASTS	Absent	Absent
CRYSTALS	Absent	Absent
BACTERIA	**Present(Few)**	Absent

Anushka Chavan
Entered By

Ms Kaveri Gaonkar
Verified By

Dr. Milind Patwardhan
M.D(Path)
Chief Pathologist

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Harshika
9704

Female

33 Years

09.12.2023 9:38:11
Apollo Clinic
1st Flr,The Emerald,Sector-12,
Vashi, Mumbai-400703.

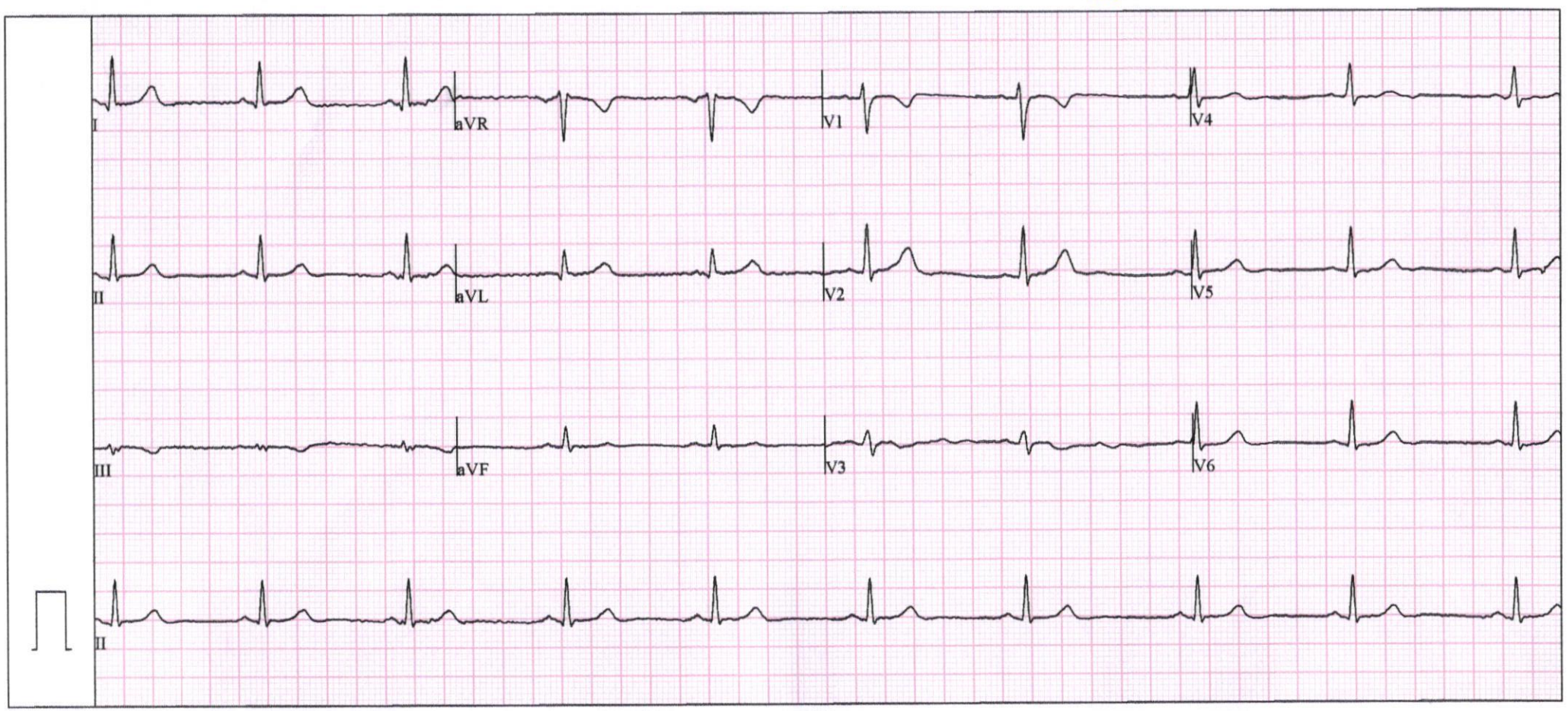
57 bpm
-- / -- mmHg

7 inversion in Isolated lead III
WNL

QRS :	80 ms
QT / QTcBaz :	398 / 387 ms
PR :	122 ms
P :	86 ms
RR / PP :	1060 / 1052 ms
P / QRS / T :	39 / 30 / 14 degrees

Sinus bradycardia
Otherwise normal ECG

Dr. Chaitanya K. Kulkarni
Consultant Physician
MBBS, DNB Medicine
Reg. No. - 2014/04/1349



GE MAC2000 1.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 50 Hz Unconfirmed 4x2.5x3_25_R1 1/1

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PATIENT'S NAME	HARSHIKA	AGE :- 33 Y/F
UHID	9704	9 Dec 2023

DIGITAL RADIOGRAPH OF CHEST (PA VIEW)

The lung fields are clear.

Heart and aorta appears normal.

Both hila appear normal.

Both costo-phrenic angles are clear.

Visualized bony thorax appears normal.

IMPRESSION: NO SIGNIFICANT ABNORMALITY IS DETECTED.

Clinico-haematological correlation is recommended.

Thanking you for the referral,
With regards,

DR. SIDDHI PATIL
Cons. Radiologist

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PATIENT'S NAME	HARSHIKA	AGE :- 33Y/F
UHID	9704	9 Dec 2023

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size, shape and echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepato-petal flow. No evidence of intra-hepatic biliary duct dilatation.

Gall Bladder appears well distended with normal wall thickness. There is no calculus or pericholecystic collection. CBD appears normal.

Visualised parts of head & body of **PANCREAS** appear normal.

SPLEEN is normal in size, and echotexture. No focal lesion seen. Splenic vein is normal.

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis or calculi or mass seen.
RIGHT KIDNEY measures 9.9 x 4.1 cm. **LEFT KIDNEY** measures 9.7 x5.2 cm.

URINARY BLADDER is well distended; no e/o wall thickening or mass or calculi seen.

UTERUS is anteverted and is normal in size, shape and echotexture; No focal lesion seen. It measures 6.8 x 3.5 x 3.2 cm; ET measures 9.9 mm.

Both ovaries are normal in size, shape and position.
RIGHT OVARY measures : 2.3 x1.4 cm, **LEFT OVARY** measures : 2.2 x 1.9 cm.

Visualised BOWEL LOOPS appear normal. There is no free fluid seen.

IMPRESSION –

- **No significant abnormality detected.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE.THE CONTENTS OF THIS REPORT REQURE CLINICAL CO-RELATION BEFORE ANY APPLICATION.

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